**MARICOPA INTEGRATED HEALTH SYSTEM HEALTH PLANS**
**PROTOCOL**

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| SUBJECT: Ablation of the Endometrium (Laser, Balloon or Roller Ball)<br><br>APPLIES TO: MHP ☒ MLTCP ☒<br>MSSP ☒ HEALTHSELECT ☒ | Protocol #: PA P128.01<br>Protocol Pages: 1<br>Attachments: Yes ☐ No ☒<br>Initial Effective Date: June 1999<br>Latest Review Date: May 2002 |

MIHS HEALTH PLANS APPROVALS:

Director, Medical Management:_____ Date:_____

Medical Director:_____ Date:_____

**PURPOSE:** The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to Ablation of the Endometrium (Laser, Balloon or Roller Ball).

**PROTOCOL**:

A. Ablation of the Endometrium (Laser, Balloon or Roller Ball)
CPT# 56356
LOS: OP

B. The prior-authorization specialist may approve if **any** of the following are present:
1. Uterus is less than 11 cm in size;

2. Chronic menorrhagia that has failed conservative treatment, including D&C and/or pharmacotherapy;

3. No evidence or malignancy or pre-malignancy;

4. Patient signs informed consent indicating the desire for no further childbearing and/or

5. Surgical candidate.

C. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.

D. This Protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.

E. If requirements are not met, Medical Director review is required.